MICHIGAN DEPARTMENT OF HEALTH & HUMAN SERVICES

Michigan Regional Trauma Report

Region 7

Prepared by Deborah Detro-Fisher
Regional Trauma Coordinator
December 2014

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EXECUTIVE SUMMARY

The Region 7 Trauma Network is one of 8 trauma networks which form the Michigan statewide trauma system. Annually, each regional trauma network is required to file a report with the Michigan Department of Health & Human Services (MDHHS) which describes progress toward system development, demonstrates on-going activity, and includes evidence that members of the regional trauma advisory committee are currently involved in trauma care.[1]

Region 7 encompasses 11,170 square miles of land and extends across the northern portion of the Michigan's Lower Peninsula and parts of the Eastern Upper Peninsula. It is comprised of 19 counties: Alcona, Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Kalkaska, Leelanau, Mackinac, Manistee, Missaukee, Montmorency, Otsego, Presque Isle, Roscommon, and Wexford.

Of the nineteen counties in Region 7, thirteen are designated as "rural", while the other six are designated as "micropolitan" by the U.S. Office of Management and Budget. The year-round population of Region 7 is approximately 500,000 persons. However, the region also experiences more than twelve million visitor-days per year due to seasonal tourism, migrant workers, and "snow-birds". Approximately twenty percent of the total population is in the pediatric age range.

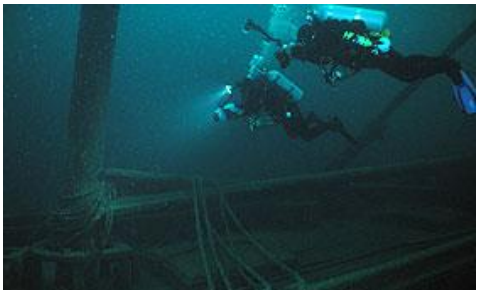


Photo Courtesy of Thunder Bay National Marine Sanctuary

The region's medical community includes seven medical control authorities (MCAs) providing medical oversight to 119 Emergency Medical Services (EMS) agencies. There are twelve hospitals in the region. Of the twelve, one (Munson Medical Center) is currently designated as a Level II Trauma Center by the State of Michigan. The remaining eleven are in the process of preparing for in-state verification and designation as trauma facilities.

SYSTEM GOVERNANCE

The Regional Trauma Network (RTN) is governed by a board of directors composed of one hospital administrator from each medical control authority located in Region 7 (Table 1). The seven medical control authorities in Region 7 are: Charlevoix Area MCA, Manistee County MCA, North Central MCA, Northeast Michigan MCA, Northern Michigan MCA, Northwest Michigan MCA and Otsego County MCA.

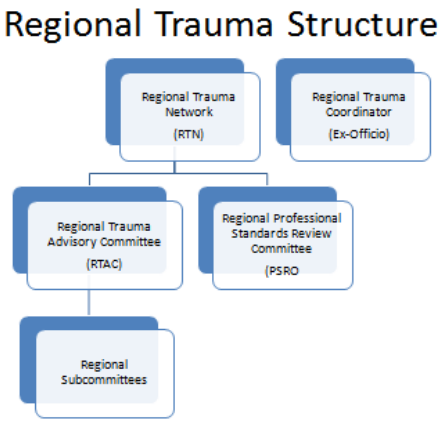
Table 1.

Medical Control Authority	Administrator	Medical Director
Charlevoix County MCA	Christine WIlhelm	Mark Smith, M.D
Manistee County MCA	Tom Kane	Richard Sharp, M.D
North Central MCA	Jennifer Furhman	Martin Lougen, M.D
Northeast MI MCA	Chuck Sherwin	Christopher Rancont, D.O.
Northern MI MCA	Mary-Anne Ponti	Thomas Charlton, M.D
Northwest Regional MCA	Kathy Garthe / Mary Neff	Robert Smith, M.D.
Otsego County MCA	Diane Fisher	David Hansmann, M.D.

[1] Michigan Statewide Trauma System Administrative Rule R 325.132.

The Regional Trauma Advisory Council (RTAC) is a committee established by the RTN whose membership is prescribed by the Michigan Administrative Rules. The Region 7 RTAC includes MCA personnel, EMS personnel, life support agency representatives, healthcare facility representatives, physicians, nurses, and consumers. There are currently over 100 persons who are participating members of the RTAC and the regional committees, providing representation for each county in the region.

The inaugural Region 7 leadership members are listed below:



Regional Trauma Network Board (RTN) Officers

- Chair: Kathy Garthe, Munson Medical Center, Northwest Regional MCA
- Vice-Chair: Chuck Sherwin, Alpena Regional Medical Center, Northeast MI MCA
- Secretary: Open

Regional Trauma Advisory Council (RTAC) Officers

- Chair: Dr. Thomas Charlton, Northern MI MCA
- Executive Committee: Dr. David Kamm, Munson Medical Center; Dr. Kal Attie, McLaren Northern Michigan Hospital; Shamarie Regenold, Munson Medical Center; and Paul Owens, Northflight EMS
- Secretary: Open

Regional Professional Standards Review Organization (RPSRO) Officers

- Chair: Dr. David Kamm, Munson Medical Center
- Staff: Deb Detro-Fisher, Region 7 Trauma Coordinator

Regional Committee Chairpersons:

- Medical Oversight - Dr. Thomas Charlton, Northern MI MCA and Dr. Scott Groseclose, Munson Medical Center
- Operations - Daryl Case, Northwest Regional MCA
- Education - Dr. Craig Boss, Charlevoix Area Hospital
- Injury Prevention - Dr. Kal Attie, McLaren Northern Michigan Hospital

PROGRESS AND ACCOMPLISHMENTS

Leadership was established and regional activities began in 2012. In both 2012 and 2013, regional stakeholders gathered together to begin conducting need assessments with corresponding actionable objectives for implementing the first phase of the regional trauma network. These trauma summits allowed all stakeholders an opportunity to share their knowledge and expertise in building a strong foundation for future growth of the system. The region received formal recognition from the State of Michigan as a regional trauma network in August, 2014,

Region 7's inaugural year culminated in a leadership summit in December of 2014 where the RTN members, RTAC leadership group, medical control directors, surgeons, and trauma program managers came together to look back at the progress made over the previous year and set the goals for the upcoming year.

During 2014, Region 7 began the process of operationalizing the Regional Trauma Network bylaws. The Regional Trauma Network Board and RTAC chairpersons were formally appointed. The Education, Injury Prevention, Medical Oversight, and Operations Committees were established by the RTN. The RTN, RTAC, and committees each met regularly throughout 2014 to work toward meeting the benchmarks set forth in the regional application work plan.

One noteworthy accomplishment was the completion of the "Destination and Bypass" protocol by the Medical Oversight Committee. The region's largest and most active committee, under the leadership of Dr. Thomas Charlton and Dr. Scott Groseclose, developed the first of several policies and protocols for the region. Evidenced-based and tailored to specifically meet the needs of the Regional Trauma System still in its infancy, the protocol satisfied an important indicator in the work plan and set the tone for collaboration, communication, and cooperation among the many stakeholders in the region. The best practices developed during this process may also be adopted by the other groups when developing their own unique policies and procedures for the region.

Many stakeholders and partners collaborated and shared their expertise and time to al Trauma System development. While 2014 was our year of organization, this coming year will certainly be the "break-out" year for creating and implementing processes designed to strengthen our regional trauma system.

DEVELOPING THE REGIONAL TRAUMA NETWORK

On August 20, 2014, Region 7 was formally recognized by the MDHHS as a Regional Trauma Network.

Each member of the RTN is responsible for representing and making decisions and commitments on behalf of their respective MCA (hospital). Collectively, the membership furthers the work and mission of the Regional Trauma Network in order to establish and maintain a regionalized, coordinated and accountable trauma system. This model ensures an all-inclusive system while allowing for accurate, efficient, and timely representation of both the MCAs and their hospital members.

The RTAC provides the content expertise, the experience, and the front line understanding of the issues, challenges, and gaps of the regional trauma system. The RTAC contributes to the development and implementation of the RTN work plan.

Looking forward, the committees will continue to develop regional guidelines, policies, and procedures for the treatment and transport of the trauma patient. A key component of each committee is the continuous assessment and evaluation of their respective section of the work plan. Likewise, the RTN will continue to monitor the overall system assuring that the vital components of coalition building, agency participation, outreach, data collection, designation, patient flow improvement and coordination, evaluation, and quality assurance are being addressed.

EPIDEMIOLOGY

Trauma is the leading cause of death in the United States for people 1–44 years of age. In 2011, more persons between the age of 1-44 died as a result of their injuries than those who died of all non-communicable diseases and infectious diseases combined [2] (Table 2). There are more than 187, 000 deaths from injury each year, or one person every three minutes. An estimated 32.4 million people are treated in emergency departments for injury each year with an average 2.8 million people hospitalized as a result of those injuries. Violence and injuries cost more than $406 billion in medical care and lost productivity each year[3]

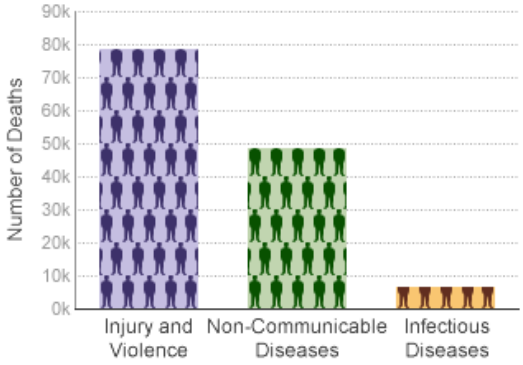


Table 2.

The leading causes of injury related deaths in Region 7 are motor vehicle crashes[4]. There were 23,838 drivers involved in 17,555 motor vehicle crashes in Region 7. Of those crashes, 70 were classified as fatal, resulting in 78 fatalities. An additional 3,105 persons were injured. The second leading of cause of injury related deaths in Region 7 is suicide followed closely by falls[5] (Table 3).

The leading cause of injury related hospitalization in Region 7 is falls. Motor vehicle crashes and blunt trauma account for the second and third leading causes of injury related hospitalizations respectively (Table 4).

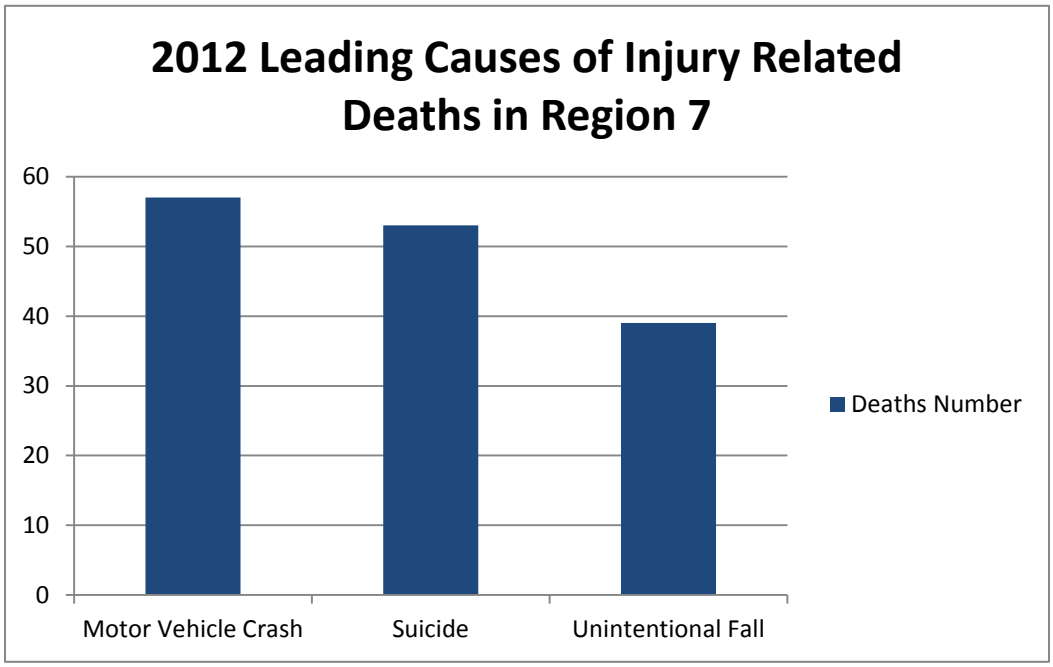


Table 3.

[2] NCIPC: Web-based Injury Statistics Query and Reporting System (WISQARS)

[3] Finkelstein EA, Corso PS, Miller TR, Associates. Incidence and Economic Burden of Injuries in the United States. New York, NY: Oxford University Press; 2006

[4] Source: http://www.michigantrafficcrashfacts.org/

[5] Source: Thomas W. Largo, MPH, Division of Environmental Health, Bureau of Disease Control, Prevention, and Epidemiology, Michigan Department of Health & Human Services, 2012 data.

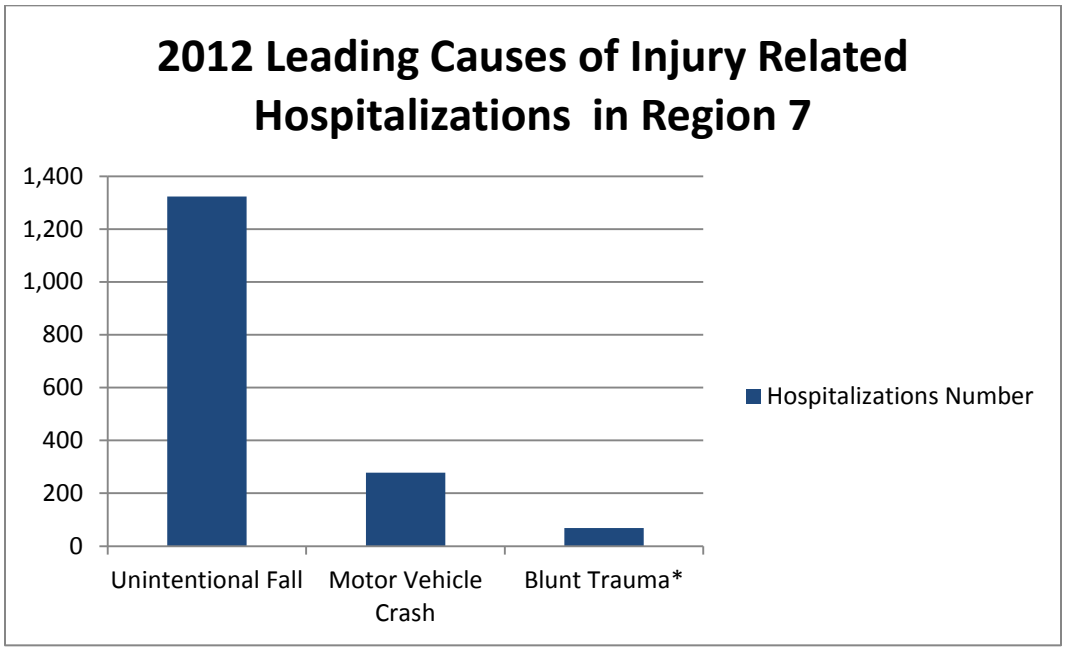


Table 4.

Source: Thomas W. Largo, MPH, Division of Environmental Health, Bureau of Disease Control, Prevention, and Epidemiology, Michigan Department of Health & Human Services, 2012 data.

THE REGIONAL WORK PLAN

The regional work plan is the tool utilized by each regional trauma network to guide and measure progress toward developing and operationalizing the components of a successful trauma system. It is a written plan prepared by the RTAC, and approved by the RTN, that is based on minimum criteria established by the Michigan Department of Health & Human Services, and addresses each of the following trauma system components: system governance; injury prevention; citizen access to the system; trauma system communications; medical direction; pre-hospital triage criteria; trauma diversion policies; trauma bypass protocols; transfers; regional trauma treatment guidelines; regional quality improvement plans; and trauma education. Each of these components contains benchmarks which are the overarching goals, expectations, or outcomes. In the context of the trauma system, a benchmark describes a broad system attribute. Each benchmark is followed by a series of indicators which are the tasks or outputs that characterize the benchmark. Indicators identify actions, or capacities, within the benchmark that are measurable components[6].

Each of the following eleven subsections corresponds with the eleven work plan components. The subsection begins with the 2006 HRSA *Model Trauma System Planning and Evaluation* indicator/benchmark, followed by progress toward that indicator during FY 2014 ("Achievements"), and concluding with objectives for 2015 ("2015 FOCUS").

[6] United States Health and Resource Service Administration, "Model Trauma System Planning and Evaluation". 2006.

SYSTEM GOVERNANCE

Benchmark: Each region shall establish a regional trauma network. All MCAs within a region must participate in a regional network, and life support agencies shall be offered membership on the RTAC. Regional trauma advisory committees shall maximize the inclusion of their constituents. The regional trauma network establishes a process to assess, develop, and evaluate the trauma system in cooperation with the regional stakeholders in trauma care.

ACHIEVEMENTS

In 2014, the primary focus of the RTN Board was to operationalize the regional bylaws and to put into place the organizational structures necessary to accomplish the 2014 work plan objectives. RTN Board established a Regional Trauma Advisory Council (RTAC) which currently is made up of over 100 persons representing all disciplines required under the trauma administrative rules. Thomas Charlton, DO was appointed chairman of the council. The RTN also appointed a four person executive team to provide added knowledge and expertise in matters of coalition and trauma system development: David, Kam, MD and Trauma Program Director for Munson Medical Center; Shamarie Regenold, Trauma Program Manager for Munson Medical Center; Kal Attie, DO, Emergency Department Physician, McLaren Northern Michigan Hospital and Medical Director for the Region 7 Healthcare Preparedness Network; and Paul Owens, Paramedic, Manager Northflight Ground Operations representing EMS. The RTAC meets quarterly via teleconference.

The RTN Board also approved the creation of four subcommittees. Careful thought was put forth into ensuring that the committees were inclusive and representative of the region's stakeholders. The subcommittees established in 2014 are the Medical Oversight, Operations, Injury Prevention, and Education. These committees meet monthly to work toward accomplishing the objectives of their assigned component(s) of the regional work plan.

2015 FOCUS

The focus of the RTN for 2015 will be to continue to ensure that the system is inclusive and adequately represented by the member organizations. The RTN will also continue to support coalition building by inviting more organizations to the table.

INJURY PREVENTION

Benchmark: The RTN, in cooperation with other agencies and organizations, uses analytical tools to monitor the performance of population-based (regional) injury prevention programs.

ACHIEVEMENTS

Each member of the RTN identified at least one person from each of the participating hospitals in their MCA to serve as a representative to the Region 7 Injury Prevention Committee. By doing so, each of the region's hospitals took the first step in demonstrating participation in regional injury prevention activities which is a requirement for designation as a trauma facility in Michigan. The committee then began the process of identifying and inviting others with injury prevention program expertise from their respective MCA regions to participate in developing the regional injury prevention program. Simultaneously, the membership began the process of identifying the type, number, and success of injury prevention programs currently being offered in the region. This information will assist the committee in ensuring a coordinated approach to meeting the injury prevention needs of the region.

2015 FOCUS

- Throughout 2015, the Injury Prevention Committee will continue to concentrate on identifying new partners in an effort to establish a membership representative of all disciplines and community partners with a stake in injury prevention.
- By April 30, 2015, the Injury Prevention Committee will have developed a written set of goals and SMART objectives (Specific, Measurable, Attainable, Relevant and Time-bound) for the region's injury prevention and control plan.
- The Injury Prevention Committee will have established a process for identification, monitoring and evaluation of injury prevention activities and programs in the region as evidenced by a written procedure for inclusion in the region's injury prevention and control plan. The target date for completion is June 30, 2015.
- By June 30, 2015, the Injury Prevention Committee will have identified the top 5 injury mechanisms in the region for adults and for children as reported to the RTN in subcommittee meeting minutes.
- By September 30, 2015, the Injury Prevention Committee will have conducted a regional needs assessment based on data received from the inventory survey.

CITIZEN ACCESS TO THE SYSTEM

Benchmark: The trauma system is supported by EMS medical oversight of dispatch procedures and coordinated response resources. The trauma system EMS medical directors are actively involved with the development, implementation, and ongoing evaluation of EMS system dispatch protocols to ensure they are congruent with the trauma system design. These protocols include, but are not limited to, which resources to dispatch (Advanced Life Support or Basic Life Support), air-ground coordination and early notification of the trauma facility, pre-arrival instructions, and other procedures necessary to ensure dispatched resources are consistent with the needs of injured patients. There are sufficient, well-coordinated air and ground ambulance resources to ensure EMS providers arrive at the trauma scene to promptly and expeditiously transport the patient to the correct hospital by the correct transportation mode.

ACHIEVEMENTS

In 2014, the RTN established the Region 7 Operations Committee to address regional objectives related to citizen access to the trauma system and trauma system communications. The over-arching goal of the committee is to support the provision of EMS medical oversight of dispatch procedures, coordination of response resources, and a coordinated communication system linking and integrating hospitals, life support agencies, the EMS system, and the Regional Trauma Network.

This committee is open to all stakeholders in Region 7 and includes both hospital and pre-hospital representation. In September of 2014, an open invitation was sent to all 911 Central Dispatch Directors in Region 7 to participate as members of the Operations Committee. In December, this invitation was further extended to the Region 7 Emergency Managers by way of their liaison from the Region 7 Homeland Security Board.

Dialogue was started with the Region 7 Central Dispatch Directors to work towards a regionalized trauma dispatch protocol. A short survey was conducted across the region to obtain key information regarding the practices utilized when dispatching life support agencies, Of the 17 dispatch centers surveyed, 71% reported that they utilize a nationally recognized Emergency Medical Dispatch (EMD) system (either computerized or flip-cards) to aid in the dispatch of life support agencies. Nine dispatch centers use the International Association of Emergency Dispatchers – Priority Dispatch® software while the other three use the Powerphone® software. A side-by-side comparison of the trauma patient protocols in each of the

fore-mentioned EMD systems was conducted with no appreciable difference discovered between the two systems. The consensus of the committee was that if all dispatch centers routinely utilized one of the two systems, there would be some level of consistency among the dispatch protocols across the region with the exception of those dispatch centers that have yet to adopt a formal EMD system.

2015 FOCUS

The Operations Committee will develop a regionalized trauma dispatch protocol that will allow for Advanced Life Support vs. Basic Life Support, air-ground coordination and early notification of the trauma facility, pre-arrival instructions, and other procedures necessary to ensure dispatched resources are consistent with the needs of injured patients as evidenced through MDHHS approved protocols. This protocol will be completed and provided to the RTAC/RTN by September 30th, 2016.

TRAUMA SYSTEM COMMUNICATIONS

Benchmark: The regional trauma system is supported by a coordinated communication system linking and integrating hospitals, life support agencies, the EMS system, and the RTN. There are established procedures for EMS and trauma system communications for major EMS events and multiple jurisdiction incidents that are effectively coordinated with the overall regional response plans. There is a procedure for communications among medical facilities when arranging for inter-facility transfers including contingencies for radio or telephone system failure.

ACHIEVEMENTS

The Region 7 Operations Committee adopted a common procedure for EMS and trauma system communications for major EMS events and multiple jurisdiction incidents that is coordinated with the regional disaster response plans. The region designated a common primary and backup mode of inter-hospital communications for arranging for inter-facility transfers.

2015 FOCUS

- By September 30, 2015, all MCAs in the region will have adopted a common procedure which delineates the information which must be communicated by hospitals when arranging for the inter-hospital transfer of a trauma patient, as evidenced by inclusion in a regional protocol.
- By September, 2015, all MCAs in the region will have a letter on file which states that a common regional EMS protocol which includes the procedures outlined in the achievements section above and has been approved for adoption by the department.

MEDICAL OVERSIGHT

Benchmark: The regional trauma system is supported by active EMS medical oversight of trauma communications, pre-hospital triage, treatment, and transport protocols. There is well defined regional trauma system medical oversight integrating the specialty needs of the trauma system with the medical oversight of the overall EMS system. There is a clearly defined, cooperative, and ongoing relationship between regional trauma physician leaders and the EMS system medical directors in the region.

ACHIEVEMENTS

In 2014, the RTN formally established the Region 7 Medical Oversight Committee for the purpose of providing a forum for collaboration on regional trauma policy and procedures. The committee meets monthly through an internet-based audio/video application and is regularly attended by trauma surgeons, medical control physicians, emergency department physicians, trauma program managers, nursing, and EMS personnel. Under the leadership of co-chairpersons Thomas Charlton, M.D., and Scott Groseclose, M.D., the Medical Oversight Committee has developed strong partnerships between many of the stakeholders in the region's trauma community.

2015 FOCUS

- The Medical Oversight Committee will continue to meet on a regular basis and continue efforts to encourage participation of the region's surgeons, MCA directors, and physicians.
- The committee will continue to evaluate the effectiveness of the system and work together to implement any improvements that are necessary to optimize the efficiency of patient care and transport.

PRE-HOSPITAL TRIAGE CRITERIA

Benchmark: The regional trauma system is supported by system-wide pre-hospital triage criteria. The region has adopted mandatory regional pre-hospital triage protocols to ensure that trauma patients are transported to an appropriate trauma center based on their injuries. The triage protocols are regularly evaluated and updated to ensure acceptable and region-defined rates of sensitivity and specificity for appropriate identification of a major trauma patient.

ACHIEVEMENTS

In August of 2014, the Medical Oversight Committee met the Region 7 work plan deadline for drafting a regional pre-hospital triage protocol, consistent with the intent of the CDC Guidelines for the Field Triage of Injured Patients. Subsequently the RTN adopted the same protocol which is now titled "Trauma Destination and Bypass Criteria".

2015 FOCUS

By July 31, 2015, all MCAs in the region will have adopted a regional pre-hospital triage protocol to ensure that trauma patients are transported to an appropriate trauma center based on their injuries as evidenced by letters indicating approval of said protocol by MDHHS-EMS.

TRAUMA DIVERSION POLICIES

Benchmark: Diversion policies ensure that acute care facilities are integrated into an efficient system to provide optimal care for all injured patients. The regional trauma network plan should ensure that the number, levels, and distribution of trauma facilities are communicated to all partners and stakeholders. The RTN should develop procedures to insure that trauma patients are transported to an appropriate facility that is prepared to provide care. The state trauma registry is used to identify and evaluate regional trauma care and improve the allocation of resources.

ACHIEVEMENTS

The Medical Oversight Committee was assigned the task of developing the trauma diversion policy. The topic remains under discussion. In the interim, the consensus was that the topic is currently sufficiently covered in the State of Michigan "Destination and Diversion Guidelines" protocol.

2015 FOCUS

- By June 30, 2015, the RTN will have identified and communicated the current number, levels, and distribution of trauma facilities to all regional stakeholders as evidenced through copies of written communications.
- By September 30, 2015, the EMS medical oversight subcommittee will develop a facility diversion plan as evidenced by submission of said plan to the RTN for approval.
- By December 31, 2015, the RTN will have formally adopted the facility diversion plan as demonstrated in meeting minutes.

TRAUMA BYPASS PROTOCOLS

Benchmark: The roles, resources and responsibilities of trauma care facilities are integrated into a resource efficient, inclusive network that meets standards and provides optimal care for injured patients. The regional trauma plan has clearly defined the roles, resources and responsibilities of all acute care facilities treating trauma, and of facilities that provide care to specialty populations (spinal cord injury, burns, pediatrics, other). There is a regional trauma bypass protocol that provides EMS guidance for bypassing a trauma care facility for another more appropriate trauma care facility.

ACHIEVEMENTS

The Medical Oversight Committee incorporated the trauma bypass protocol into the "Trauma Destination and Bypass" protocol. Please reference "Pre-Hospital Triage Criteria" benchmark above for a detailed explanation of the status of that protocol.

2015 FOCUS

By June 30, 2015, the Medical Oversight Committee will have developed an addendum to the "Trauma Destination and Bypass" protocol which provides EMS guidance for bypassing a trauma care facility for another more appropriate trauma care facility including burn, pediatric trauma, STEMI, and stroke centers.

REGIONAL TRAUMA TREATMENT GUIDELINES

Benchmark: The regional trauma network ensures optimal patient care through the development of regional trauma treatment guidelines. When injured patients arrive at a medical facility that cannot provide the appropriate level of definitive care, there is an organized and regularly monitored system to ensure that the patients are expeditiously transferred to the appropriate, system-defined trauma facility. Collected data from a variety of sources is used to review the appropriateness of all-inclusive regional trauma performance standards, from injury prevention through rehabilitation.

ACHIEVEMENTS

The Medical Oversight Committee began the process of developing a trauma transfer protocol to ensure patients are expeditiously transferred to an appropriate level trauma center.

2015 FOCUS

- By May 31, 2015, the Medical Oversight Committee will have finalized and submitted the trauma transfer protocol to the RTN for adoption.
- By December 31, 2015, the Medical Oversight Committee, with input from the RPSRO, will have developed written, quantifiable regional system performance standards for each component of the regional trauma system that conform to standards outlined in the Michigan Administrative Rules.

REGIONAL QUALITY IMPROVEMENT PLANS

Benchmark: The RTN/RTAC uses system data to evaluate system performance and regularly reviews system performance reports to develop regional policy. No less than once per year, the RTN generates data reports that are disseminated to all trauma system stakeholders to evaluate and improve system performance.

ACHIEVEMENTS

The RTN approved establishing, and subsequently appointed, the Regional Professional Standards Review Organization (RPSRO) in accordance with the revised Region 7 Bylaws. The RPSRO adopted a schedule of quarterly meetings to begin in 2015.

2015 FOCUS

- All members of the RPSRO will be required to sign and place on a file a copy of the State of Michigan Data Use Agreement.
- The RPSRO, in conjunction with the RTN, will begin monitoring and reporting the timely submission of data into the State Trauma Registry (ImageTrend®) by hospitals planning to seek trauma center designation.
- The RPSRO will draft a regional PSRO plan for adoption by the RTN by July 31, 2015.
- The RPSRO committee will begin submitting an annual report of system performance to the RTN for approval no later than December 31, 2015.

TRAUMA EDUCATION

Benchmark: The RTN ensures a competent workforce through trauma education standards. The regional network establishes and ensures that appropriate levels of EMS, nursing and physician trauma training courses are provided on a regular basis.

ACHIEVEMENTS

The RTN established the Region 7 Education Committee composed of both hospital and pre-hospital personnel. Under the leadership of Craig Boss, M.D., the committee commenced the task of establishing regional trauma training recommendations for physicians, mid-level providers, nurses, and EMS personnel. The committee recommended Region 7 adopt the minimum education standards for trauma center verification as set forth by the "American College of Surgeons Committee on Trauma".[7]

[7] Reference: American College of Surgeons Committee on Trauma. "*Resources for Optimal Care of the Injured Patient*", 2014.

2015 FOCUS

- By March 31, 2015, the Region 7 Education Committee will begin collaborating with other regional trauma committees in meeting established trauma education benchmarks.
- By June 30, 2015, the committee will have drafted a process to inform and educate all personnel on new protocols and treatment approaches as system changes are identified.
- By June 30, 2015, the committee will have completed a regional inventory of available trauma education programs.
- By September 30, 2015, the regional Education Committee will have developed a plan for the education of pre-hospital providers in the regional pre-hospital triage protocol as evidenced by submission of the plan to the RTN for formal approval.
- By September 30, 2015, the committee will have created a mechanism for sharing information about regional and state-wide trauma education opportunities with stakeholders.

BEST PRACTICES / SUCCESSES

There were numerous best practices that came out of Region 7's first year of formal activity. The focus on collaboration and cooperation, and the continued efforts to engage our stakeholders, solidified the region's organizational structure. Emphasis placed by the region's physicians and surgeons on utilizing evidenced-based medicine when crafting policies and procedures gave the region's output the required credibility to ensure adoption and adherence.

Perhaps the most important accomplishment achieved in Region 7 was the ability to bring stakeholders from all over the region to collaborate on the implementation of a program that will benefit all trauma patients. The RTN, RTAC, and committees have been established and are all actively engaged in the development of policies, procedures and protocols. Injury prevention and trauma education programs are in the developmental stages and collaboration with other regional trauma networks on the creation of surveys is being planned. The RPSRO leadership has been appointed and meetings are already scheduled throughout 2015 to develop processes and begin to review regional trauma cases and data. The Region Trauma Network has done an excellent job over the past twelve months.

SUMMARY

In summary, the citizens and visitors to Region 7 have much for which to be thankful. To an already long list of regional attributes, they can now begin to see and benefit from the dedication of the medical community to developing a system which provides optimal care to the trauma patient.

Region 7 Trauma Network

"Getting the Right Patient to the Right Place at the Right Time."